SUFFOLK COUNTY MUNICIPAL EMPLOYEES BENEFIT FUND

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TRUSTEES
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CHAIRPERSON
MICHELE A. O'CONNELL
STANLEY J. HUMIN III
CHRISTINA A. MAHER

Dependent Statement

Part A (To be completed by Member) **Please Print or Type**

Member's Name Benefit Fund ID #

Home Address

Dependent's Name Dependent's Date of Birth Relationship

Part B (To be completed by Attending Physician) **Please Print or Type**

Physician's Name

Physician's Address

Is this dependent incapable of self-support by reason of mental or physical disability? ____YES ____NO

Onset of condition (date) _____

Date dependent became incapable of self support. _____

Estimated duration of Disability _____

Date of most recent examination of Patient _____

Complete medical diagnosis:

Please note: Unless all questions are answered completely, a determination cannot be made.
If more space is needed , please use back of form.

_____ _____
Date Signature

Office Use Only

_____ Approved
_____ Temporarily Approved through _____
_____ Disapproved for the following reason _____

_____ _____
Date Signature